



REFLUX ESOPHAGITIS AN OVERVIEW

By

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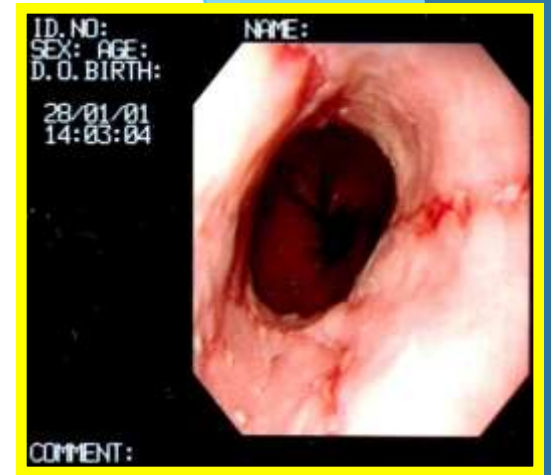
Introduction

- ▶ The esophagus is a flattened muscular tube of 18 to 26 cm from the upper sphincter to the lower sphincter. Between swallows the esophagus is collapsed but the lumen can distend to approximately 2cm in the antero-posterior dimension and up to 3cm laterally to accommodate a swallowed bolus.

► Normal Esophagus - Endoscopy

- Black arrow marks the squamo-columnar junction(Z-Line)
- Note that the Z-Line while undulating has smooth contours
- Green arrow marks gastric columnar epithelium above the sphincter which is seen as a round black hole
- Red arrow marks the pink white esophageal squamous epithelium





**Not all esophagitis
are GERD**

Causes of esophagitis

- Reflux esophagitis
- Infections
- Medications
- Radiation therapy
- Systemic disease
- Trauma(Chemicals & endo
- Eosinophilic esophagitis

The Montréal definition of GERD

"GERD is a condition which develops when the reflux of stomach content causes troublesome symptoms and/or complications"

Esophageal Syndromes

Symptomatic Syndromes

- *Typical Reflux Syndrome*
- *Reflux Chest Pain Syndrome*

Syndromes with Esophageal Injury

- *Reflux Esophagitis*
- *Reflux Stricture*
- *Barrett's Esophagus*
- *Adenocarcinoma*

Extra-esophageal Syndromes

Established Associations

- *Reflux Cough*
- *Reflux Laryngitis*
- *Reflux Asthma*
- *Reflux Dental Eros.*

Proposed Associations

- *Pharyngitis*
- *Sinusitis*
- *Idiopathic Pulmonary Fibrosis*
- *Recurrent Otitis Media*

Gastroesophageal reflux disease affects about 20% of adults, who reported at least weekly episodes of heartburn, and up to 10% complain of daily symptoms. Although most patients have mild disease, esophageal mucosal damage (reflux esophagitis) develops in up to 50%.

Pathophysiology of reflux oesophagitis:

- ▶ Transient LOS relaxations.
- ▶ Low resting LOS tone which fails to increase when the patient is lying flat, as occurs normally.
- ▶ The LOS tone fails to increase when intra-abdominal pressure is increased by tight clothing or pregnancy.
- ▶ There is increased oesophageal mucosal sensitivity to acid.

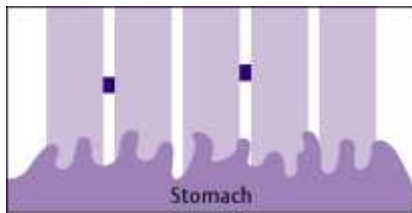
- ▶ Poor esophageal peristalsis reduces esophageal clearance of acid. The reduced acid clearance is exacerbated with a hiatus hernia, owing to trapping of acid within the hernial sac.
- ▶ A large hiatus hernia can impair the 'pinchcock' mechanism of the crural diaphragm.
- ▶ Delayed gastric emptying occurs, which may increase the chance of reflux.
- ▶ Prolonged episodes of gastro-esophageal reflux occurring at night and post-prandially.

Factors associated with gastro-oesophageal reflux

- ▶ Pregnancy or obesity
- ▶ Fat, chocolate, coffee or alcohol ingestion
- ▶ Large meals
- ▶ Cigarette smoking & alcohol
- ▶ Drugs - antimuscarinic, calcium-channel blockers, nitrates
- ▶ Systemic sclerosis
- ▶ After treatment for achalasia
- ▶ Hiatus hernia

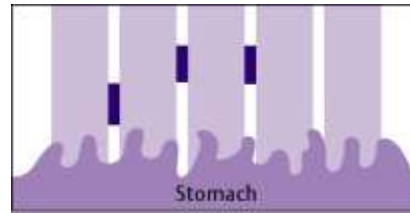
The LA Classification system for the endoscopic assessment of reflux esophagitis

Grade A



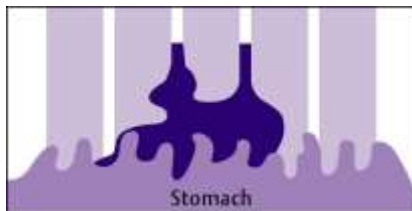
One (or more) mucosal break, no longer than 5 mm, that does not extend between the tops of two mucosal folds

Grade B



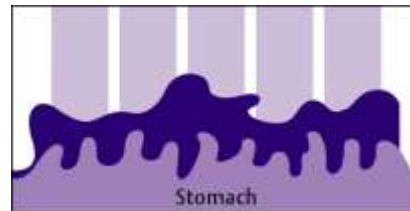
One (or more) mucosal break, more than 5 mm long, that does not extend between the tops of two mucosal folds

Grade C



One (or more) mucosal break that is continuous between the tops of two or more mucosal folds, but which involves less than 75% of the circumference

Grade D



One (or more) mucosal break that involves at least 75% of the esophageal circumference

How can GERD be diagnosed?

“The typical reflux syndrome can be diagnosed on the basis of characteristic symptoms, without diagnostic testing”

Signs and symptoms

▶ Adults

▶ The most-common symptoms of GERD are:

- ▶ Heartburn
- ▶ Regurgitation
- ▶ Trouble swallowing (dysphagia)

▶ Less-common symptoms include:

- ▶ Pain with swallowing (odynophagia)
- ▶ Excessive salivation (this is common during heartburn, as saliva is generally slightly basic and is the body's natural response to heartburn, acting similarly to an antacid)
- ▶ Nausea
- ▶ Chest pain

▶ Extra-esophageal manifestations include:

- ▶ Chronic cough
- ▶ Laryngitis (hoarseness, throat clearing)
- ▶ Asthma
- ▶ Erosion of dental enamel
- ▶ Dentine hypersensitivity
- ▶ Sinusitis and damaged teeth

Complications of reflux esophagitis

- ▶ Perforations (rare)
- ▶ Hemorrhage (7 - 18 % of esophagitis)
- ▶ Peptic strictures
- ▶ Barrett's esophagus/dysplasia
- ▶ Adenocarcinoma



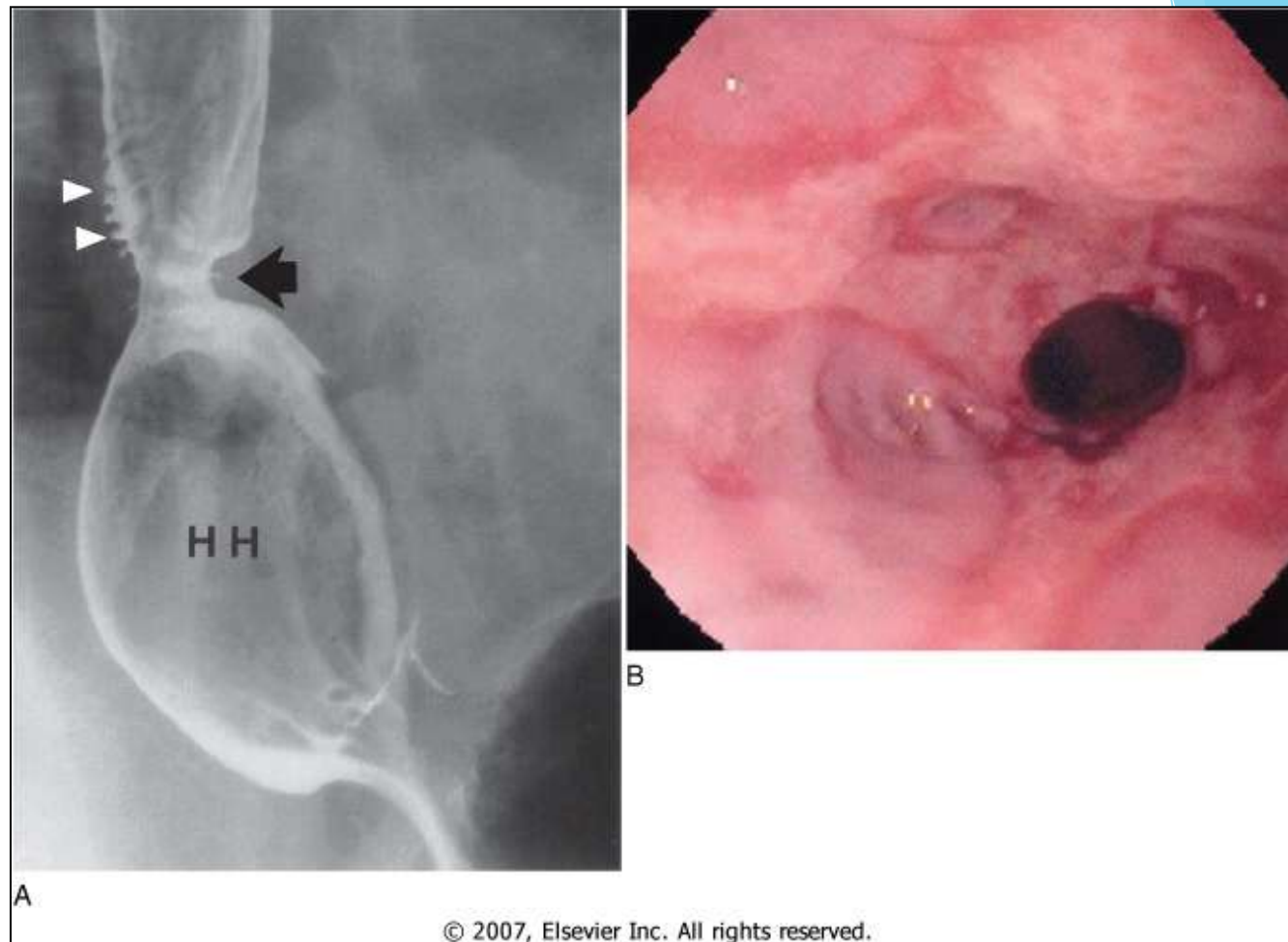


Figure 42-13 Classic peptic stricture in a patient demonstrated by barium esophagogram (A) and endoscopy (B). The film shows a large hiatal hernia (HH) common to all GERD strictures. Dark arrow points to short thick fibrous stricture with multiple pseudodiverticula (white arrows). Although not seen on barium examination, the endoscopic view also demonstrates circumferential esophagitis (Los Angeles grade D).



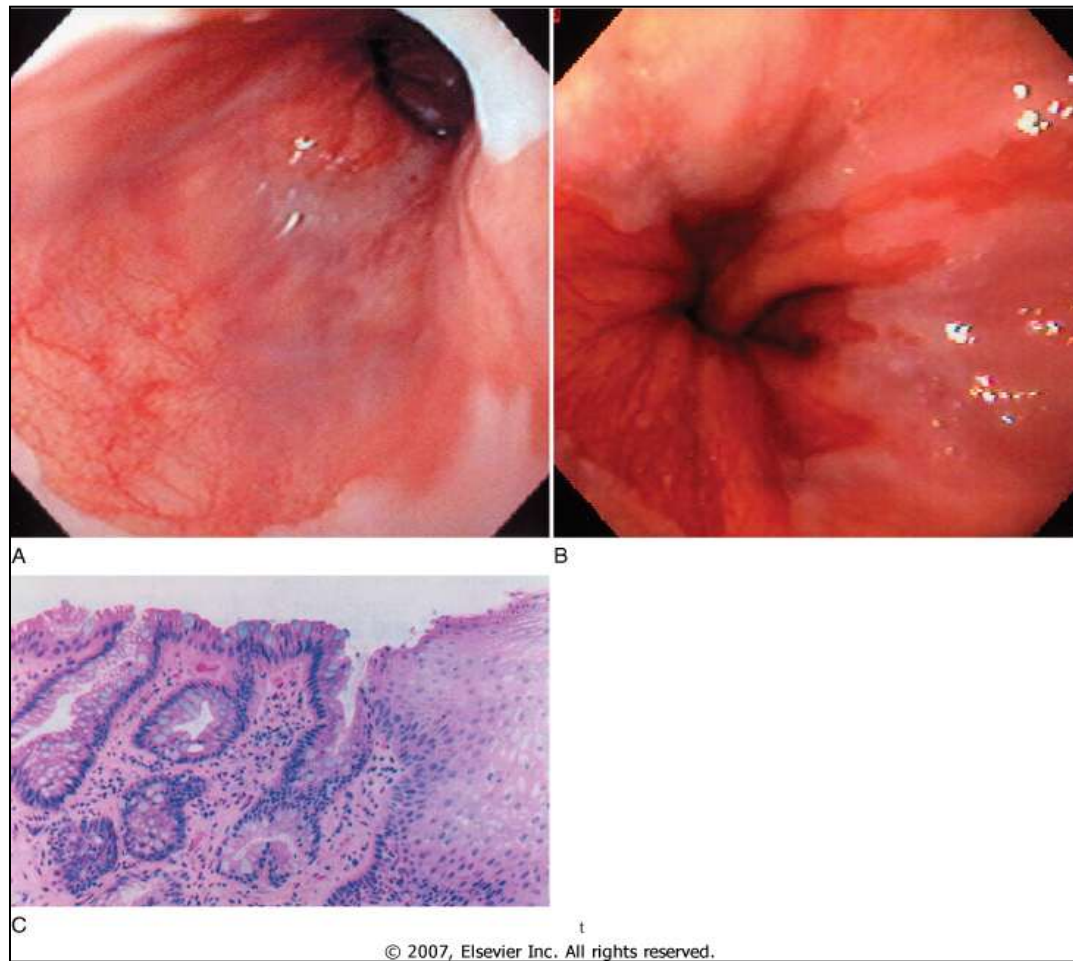


Figure 42-14 Barrett's esophagus. A, Endoscopy showing classic long-segment Barrett's esophagus with a 5 cm segment of circumferential reddish-pink columnar mucosa extending proximally from the esophageal-gastric junction. B, Short-segment Barrett's esophagus with several tongues (at 2 to 5 o'clock) above a small hiatal hernia. C, Histopathology showing specialized intestinal metaplasia with glandular epithelium and characteristic goblet cells. On the right of the photomicrograph is normal esophageal squamous mucosa. Part C reprinted from Spechler SJ, Zeroogian JM, Antonioli DA, Wang HH, Goyal RK. Prevalence of metaplasia at the gastro-oesophageal junction. *Lancet* 1994; 344:1533-6.



Alarm features for GERD

- Dysphagia.
- Odynophagia.
- Bleeding.
- Anemia.
- Weight loss.
- Fever.

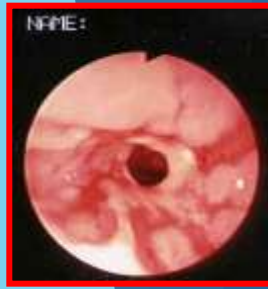
Common symptoms of Pediatric Reflux

- ▶ Irritability and pain, Constant or sudden crying or “colic” like symptoms.
- ▶ Poor sleep habits typically with arching their necks and back during or after feeding.
- ▶ Excessive vomiting.
- ▶ Frequent hiccups.
- ▶ Excessive dribbling or running nose.
- ▶ Swallowing problems, gagging and choking.
- ▶ Frequent ear infections or sinus congestion.
- ▶ Refusing feeds or frequent feeds for comfort.
- ▶ Night time coughing, extreme cases of acid reflux can cause apnoea and respiratory problems such as asthma, bronchitis and pneumonia if stomach contents are inhaled.
- ▶ Bad breath - smelling acidic.

Investigation of GERD:

- **Use Of Endoscopy**
- **Ambulatory PH monitoring**
- **Esoph. Manometry**

Use Of Endoscopy In GERD



Endoscopy at presentation should be considered in pts.

- 1- Who have symptoms suggesting complicated disease.
- 2- Those at risk for Barrett's esophagus.
- 3- when the pt. and physician feel early endoscopy to be appropriate e.g:

- *Presence of Warning signs*
- *Long Duration of symptoms*
- *Cancer phobia*

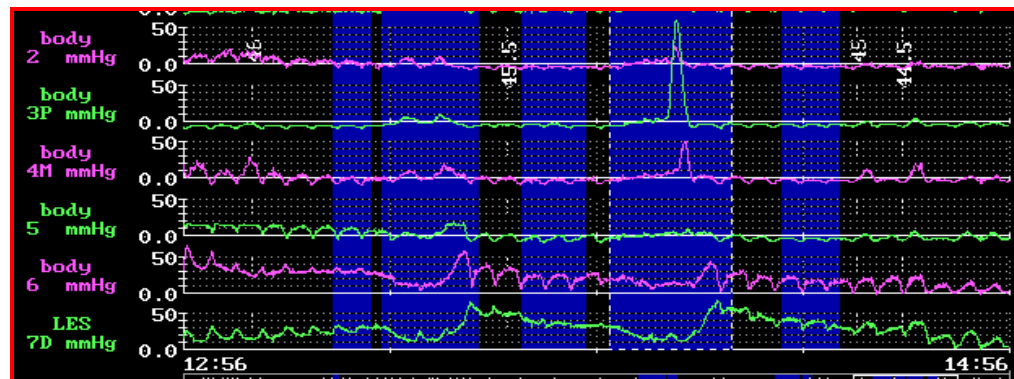
Ambulatory PH monitoring

Ambulatory monitoring of the esophagus Helps to confirm GERD in pts.

- 1- With persistent symptoms (both typical & atypical) without evidence of mucosal damage especially when a trial of acid suppression has failed.
- 2- It may also be used to monitor the control of reflux in pts. with continued symptoms on therapy.

Esophageal Manometry

Esophageal manometry may be used to(1) ensure accurate placement of ambulatory monitoring probes and(2) may be helpful prior to antireflux surgery.



The management of GERD

The goal of treatment is to provide:

- 1- symptomatic relief
- 2- healing of esophagitis (if present).
- 3- prevent complications.

In the majority of patients with uncomplicated disease, empiric treatment is initiated based on a compatible history without the need for further confirmatory studies.

Patients not responding and those with suspected complications undergo further evaluation with upper endoscopy or esophageal pH recording.

Treatment modalities include:

- ▶ *Lifestyle Modification*
- ▶ *Patient Directed therapy*
- ▶ *Acid Suppression*
- ▶ *Pro-kinetic Therapy*
- ▶ *Maintenance therapy*
- ▶ *Endoscopic Treatment*
- ▶ *Surgery*

Empirical Therapy

If the patient's history is typical for uncomplicated GERD, an initial trial of empirical therapy of PPI dose (including lifestyle modification) is appropriate.

Lifestyle modifications

Lifestyle modification may benefit many patients with GERD, although these changes alone are unlikely to control symptoms in the majority of patients. They are of limited benefits

- Weight control
- Reduction of alcohol, tobacco and coffins intake.
- Avoidance of a laying down within 2 hours of eating
- Elevating of the head of the bed.
- Avoidance of foods that trigger symptoms:
 - Spices
 - Peppermint
 - Chocolate
 - Citrus juices

Patient Directed therapy

Antacids and over-the-counter (OTC) acid suppressants are options for pts. directed therapy for heartburn and regurg.

But When

- *Symptoms persist*
- *Continuous therapy is required*
- *Alarm symptoms or signs develop*

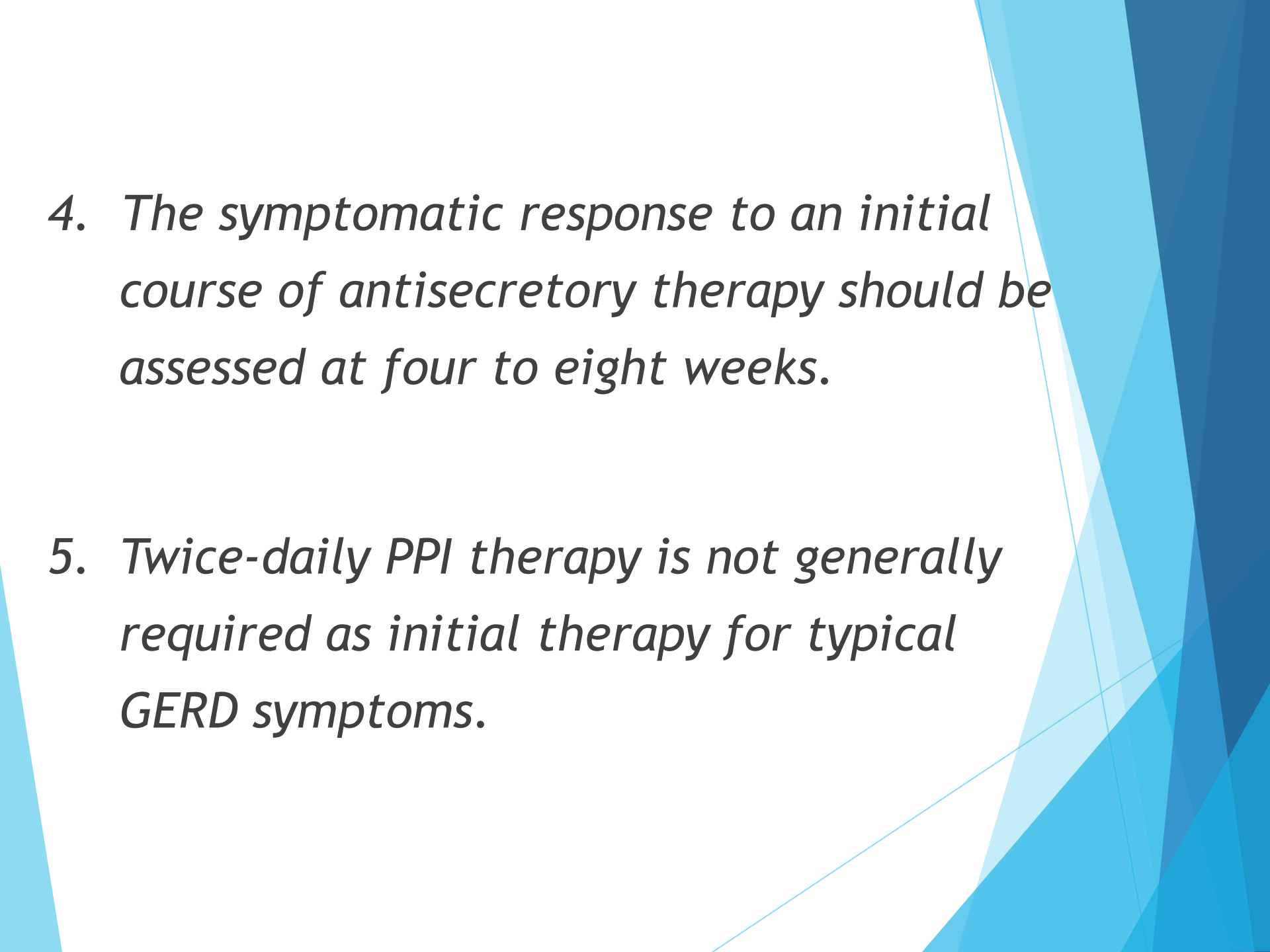


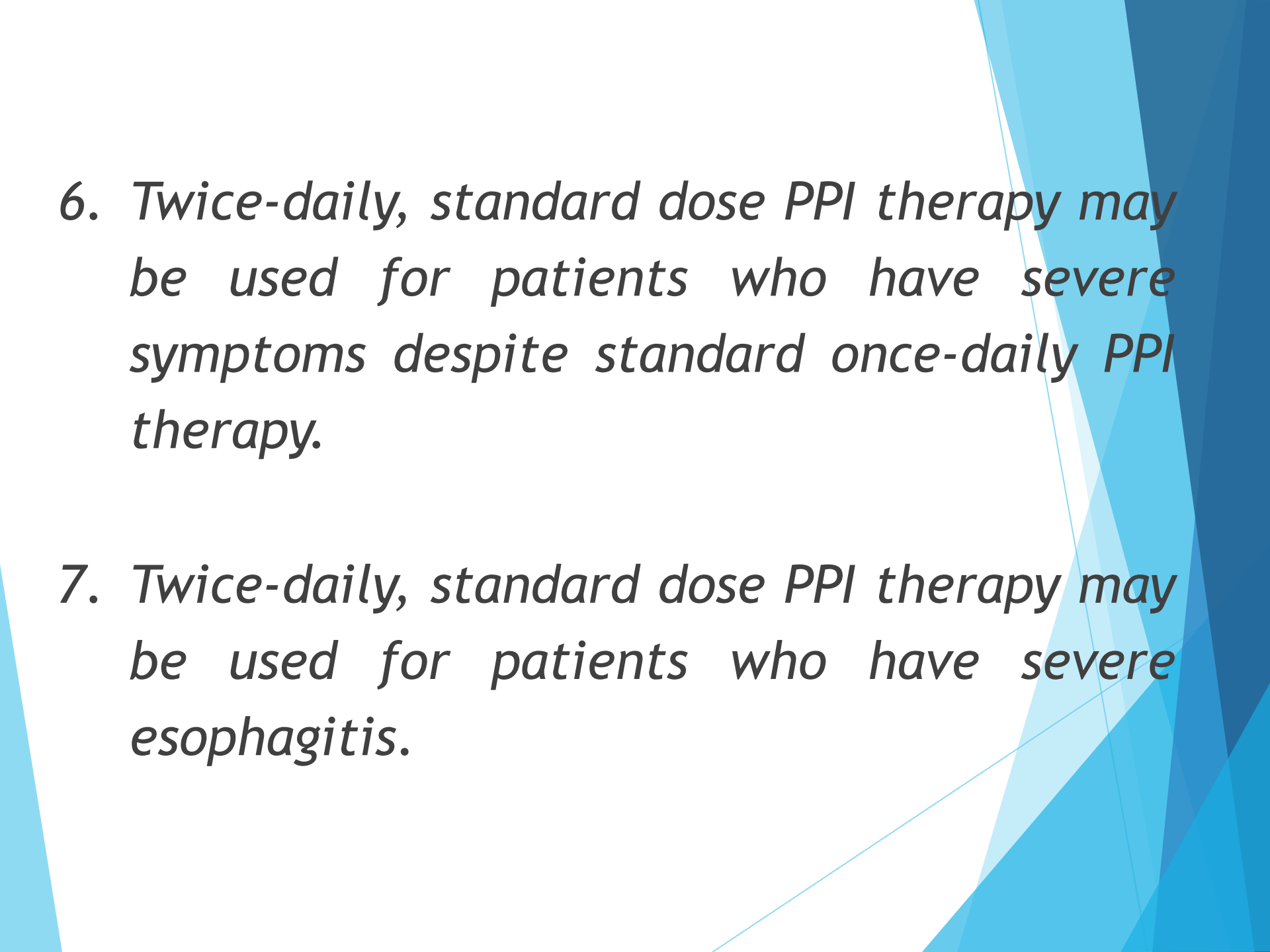
The pt. should have additional evaluation and treatment.

Acid Suppression

Acid supp. is the mainstay of therapy for GERD. PPIs provide the most rapid symptomatic relief and heal esophagitis in the highest percentage of pts. Although less effective than PPIs, Histamine 2-receptor blockers given in divided doses may be effective in some pts. with less severe GERD.

1. *PPIs are superior to H2RAs for the reduction of heartburn and healing of esophagitis.*
2. *The effectiveness of PPIs and H2RAs for the healing of esophagitis is proportional to their ability to reduce intragastric acidity.*
3. *Initial therapy for GERD symptoms should be a once-daily PPI when symptoms are mild and infrequent (fewer than three times per week).*

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4. *The symptomatic response to an initial course of antisecretory therapy should be assessed at four to eight weeks.*
 5. *Twice-daily PPI therapy is not generally required as initial therapy for typical GERD symptoms.*

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6. *Twice-daily, standard dose PPI therapy may be used for patients who have severe symptoms despite standard once-daily PPI therapy.*
 7. *Twice-daily, standard dose PPI therapy may be used for patients who have severe esophagitis.*

- PPIs are safe and effective.
- 5 available PPIs
- Always prior to meal
- Higher doses in:

1. *Supraesoph. symptoms of GERD*
2. *Partial response to standard dose*
3. *Pts with severe esoph. dysmotility*
4. *Barrett's esoph.*

Reasons for PPIs failure

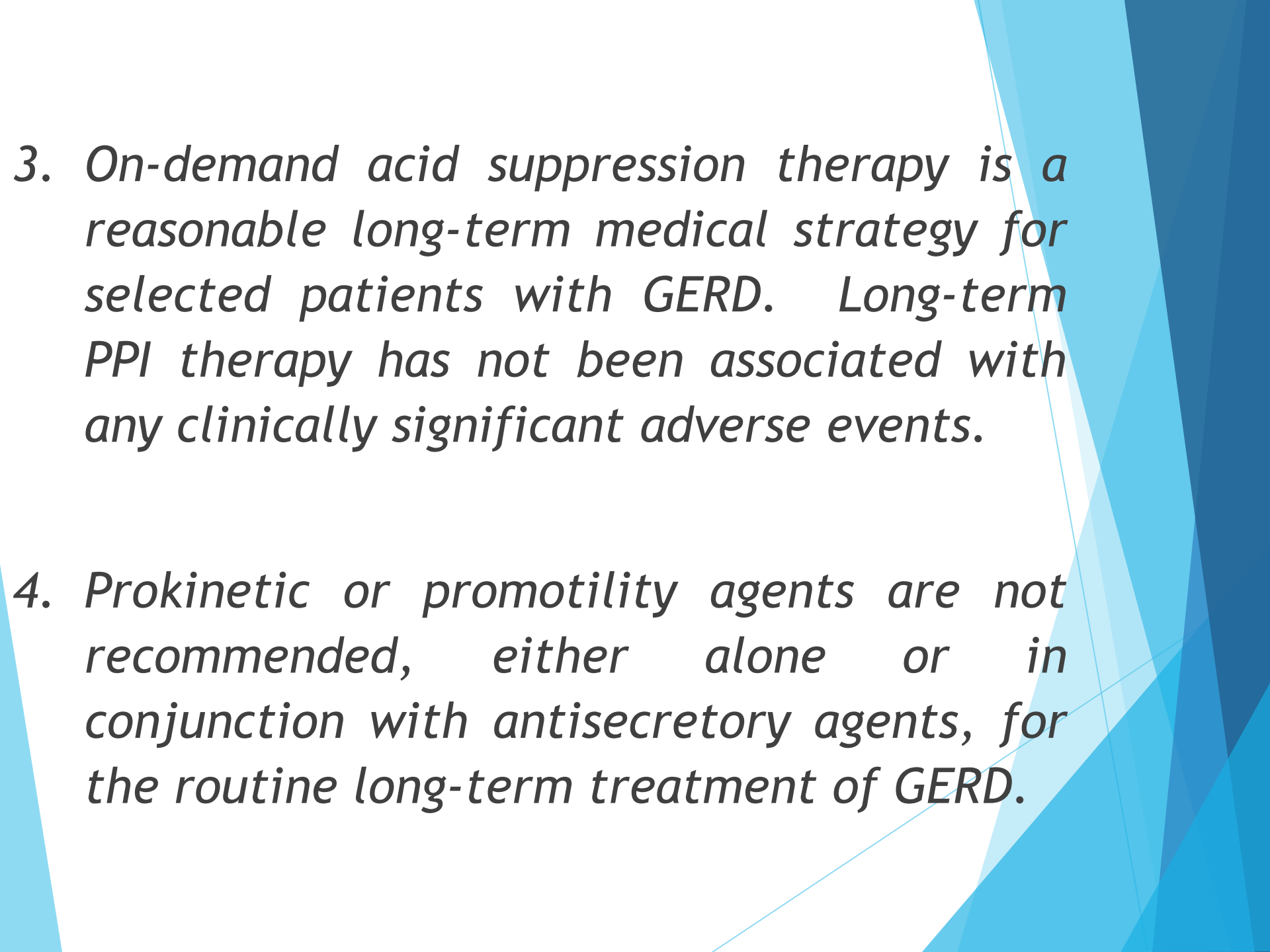
- *Oral bioavailability of PPIs varies considerably and may be decreased further when they are taken along with antacids or H_2RA s.*
- *PPIs are least effective during periods of parietal cell quiescence and have a lesser effect on acid suppression when taken at times other than just before a meal.*
- *Hypersecretors may show a diminished effect with PPIs.*
- *Genetic variations in hepatic cytochrome P 450 2C19 may result in more rapid metabolism of PPI, thereby limiting potency.*

Pro-kinetic Therapy

Pro-kinetic agents may be used in selected pts., especially as an adjunct to acid suppression.

Maintenance Therapy

1. *An individual whose reflux symptoms have responded well to standard dose PPI therapy may discontinue medication to confirm the need for ongoing therapy.*
2. *Long-term maintenance therapy should be given at the lowest dose and frequency that is sufficient to achieve optimal control of the patient's.*

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- The background of the slide features abstract, overlapping geometric shapes in various shades of blue, creating a modern, layered effect on the right side.
- 3. On-demand acid suppression therapy is a reasonable long-term medical strategy for selected patients with GERD. Long-term PPI therapy has not been associated with any clinically significant adverse events.*
 - 4. Prokinetic or promotility agents are not recommended, either alone or in conjunction with antisecretory agents, for the routine long-term treatment of GERD.*

5. *Supplementary night time H2RA therapy is not generally recommended for individuals who have responded incompletely or have failed to respond to standard dose or double dose PPI therapy of adequate duration.*

Endoscopic Treatment

- ▶ *Endoscopic Gastric Fundoplication*
- ▶ *Single Full thickness plication (Not FDA approved)*
- ▶ *Thermal Coagulation (RF) or Laser*
- ▶ *Polymer Injection*
- ▶ *Stratta (Mucosectomy)*

Anti-reflux surgery

► Fundoplication either:

- ☐ *Open surgery*

or

- ☐ *Laparoscopic*

- ☐ *Nissen 360° C fundoplication*

- ☐ *Toupet 270° C fundoplication*

Laparoscopic Anti-reflux surgery

- Safe
- Effective
- Compare favorably to continuous PPIs



Recurrence. rate	5% - 20%
Side effects	10% - 50%
Reoperation	2% - 8%
PPIs need	30%

Conclusion

- ✓ *The prevalence of GERD is high and increasing.*
- ✓ *GERD symptoms may disrupt sleep and social activities and reduce the sufferer's ability to work effectively.*
- ✓ *GERD may present with typical symptoms such as heartburn or atypical, extra-esophageal syndromes such as reflux asthma.*
- ✓ *Use of a reflux questionnaire or a 'PPI test' may help in the diagnosis of GERD.*
- ✓ *Patients with persistent GERD are at risk of Barrett's esophagus or esophageal adenocarcinoma.*

Nonerosive reflux disease NERD

- ▶ Nonerosive reflux disease (NERD) is the most common phenotypic presentation of gastroesophageal reflux disease (GERD).
- ▶ Although definition of NERD remains an area of controversy, many studies continue to define these patients as having classic symptoms of GERD in the absence of esophageal mucosal injury.
- ▶ As compared with patients with erosive esophagitis, NERD patients tend to be younger, female and lack hiatal hernia.
- ▶ NERD patients represent a complex, heterogeneous group of patients. Functional heartburn patients account for approximately half of the NERD group.
- ▶ This functional heartburn subgroup is likely responsible for the low symptom response rate of NERD patients to proton pump inhibitors (PPIs) and the rising clinical dilemma in gastrointestinal (GI) practice PPI failure.



Thank You